

Chlamydia trachomatis, and pelvic inflammatory disease. *Sex Transm Infect* 2003;**79**:154–6.

- 2 **Wolner-Hanssen P, Mårdh P-A, Svensson L, et al.** Laparoscopy in women with chlamydial infection and pelvic pain: a comparison of patients with and without salpingitis. *Obstet Gynecol* 1983;**61**:299–303.
- 3 **Stacey C, Munday P, Thomas B, et al.** Chlamydia trachomatis in the fallopian tubes of women without laparoscopic evidence of salpingitis. *Lancet* 1990;**336**:960–3.
- 4 **Taylor-Robinson D.** Mycoplasma genitalium—an up-date. *Int J STD AIDS* 2002;**13**:145–51.

Lack of evidence for sexual transmission of hepatitis C virus in patients attending STD clinics in Pune, India

The presence of hepatitis C virus (HCV) RNA in semen among two of six (33%) HIV negative and six of 15 (40%) HIV infected males, reported recently suggests that HIV may facilitate genital shedding and subsequent sexual transmission of HCV.¹ We determined HCV prevalence and examined evidence for its sexual transmission in a cohort of STD patients with observed HIV prevalence of 21.2%.

Consecutive serum samples (n = 9141) collected between January 1994 and December 1999 were batched, pooled, and tested for anti-HCV antibody (Ortho HCV 3.0, Ortho-clinical Diagnostic, Germany). As previously described,² 25 µl aliquots of five samples were pooled and 20 µl of each pool were screened. Samples from positive pools were then tested individually. Positive sera were tested by HCV RNA polymerase

chain reaction (PCR) using standard primers.³ HIV antibody status of each sample was ascertained using the algorithm described previously.⁴ Data were analysed using statistical package SPSS version 10.0. This study was a part of a prospective cohort study that was approved by ethics committee/institutional review boards of the collaborating organisations and blood samples were collected after counselling and informed consent.

Overall prevalence of anti-HCV antibodies was 0.68% (62/9141, 95% CI 0.52 to 0.87). The prevalence among HIV infected individuals (1.5%, 95% CI 1.0 to 2.1) was higher (p = <0.01) than that in those not infected (0.44%, 95% CI 0.3 to 0.6). The annual anti-HCV antibody prevalence rate between 1994 and 1999 was 0.57%, 0.46%, 1.10%, 0.81%, 0.37%, and 0.61%, which did not change significantly over time (table 1). Of the 55 anti-HCV antibody positive sera tested, 27 (49%) were HCV RNA PCR positive.

Univariate analysis revealed that history of past or current STD was not associated with HCV, whereas female sex (OR = 2.07, 95% CI 1.17 to 3.66), prevalent HIV infection (OR = 3.38, 95% CI 2.05 to 5.58), history of tattoo (OR = 2.18, 95% CI 1.31 to 3.63), and being a sex worker (OR = 2.35, 95% CI 1.27 to 4.35) were significantly associated with presence of anti-HCV antibody. However, multivariate analysis revealed that prevalent HIV infection and tattooing increased the likelihood of presence of anti-HCV antibodies by 3.08-fold (AOR 3.08, 95% CI 1.86 to 5.11, p = <0.00) and 1.87-fold (AOR 1.87, 95% CI 1.12 to 3.13, p = 0.017), respectively (table 1).

A rapid spread and high HCV prevalence of 80% has been reported recently among a cohort of injecting drug users from Kolkata, India.⁵ In contrast, we observed a low and stable prevalence of anti-HCV antibody among STD clinic attendees over the past 6 years in an urban setting where HIV transmission was predominantly sexual. Given that a high HIV prevalence was reported among female sex workers (FSWs) in this population⁴ and about 70% of males attending STD clinic had visited FSWs in the past 3 months, stable HCV prevalence over 6 years suggests that HCV is not efficiently transmitted sexually. Additionally, no association was found between past or current STD and HCV prevalence, and a high prevalence and incidence of HBV, a known sexually transmitted infection, have been reported in this population.⁶ Our analysis failed to identify any evidence that could support sexual transmission of HCV.

A Risbud, M Pereira, S Mehendale, R Gangakhedkar, M Ghate, S Joshi, S Tripathy
National AIDS Research Institute, Pune, India

R Bollinger
Johns Hopkins Medical School, Baltimore, MD, USA

R Paranjape
National AIDS Research Institute, Pune, India

Correspondence to: Dr Arun Risbud, National AIDS Research Institute, G-73, MIDC, Bhosari, Post Box 1895, Pune 411 026, India; arunrisbud@yahoo.com or hivnet@vsnl.com

Accepted for publication 18 June 2003

Table 1 Characteristics of study participants and association with prevalent anti-HCV antibody

Variable	No	Anti-HCV antibody positive (%)	Unadjusted OR (95% CI)	p Value	Adjusted OR (95% CI)*	p Value*
1 Year screened					Not included in multivariate analysis	
1994	1901	11 (0.57)	1 (Referent)			
1995	1933	9 (0.46)	0.80 (0.33 to 1.94)	0.628		
1996	1997	22 (1.10)	1.91 (0.93 to 3.96)	0.08		
1997	1109	9 (0.81)	1.41 (0.58 to 3.40)	0.45		
1998	1064	4 (0.37)	0.65 (0.21 to 2.04)	0.459		
1999	1135	7 (0.61)	1.07 (0.41 to 2.76)	0.895		
TOTAL	9139	62 (0.67)				
2 Males who had contact with sex worker					Not included in multivariate analysis	
YES	6281	40 (0.69)	1.63 (0.69 to 3.86)	0.259		
NO	1535	6 (0.39)	1 (Referent)			
TOTAL	7816	46 (0.58)				
3 Sex						
Women	1323	16 (1.21)	2.07(1.17 to 3.66)	0.013		0.469
Men	7816	46 (0.59)	1 (Referent)			
Total	9139	62 (0.67)				
4 Sex worker						
Yes	933	13 (1.39)	2.35 (1.27 to 4.35)	0.006		0.231
No	8206	49 (0.59)	1 (Referent)			
Total	9139	62 (0.67)				
5 HIV serostatus						
Pos	2102	31 (1.47)	3.38 (2.05 to 5.58)	<0.001	3.08 (1.86 to 5.11)	<0.001
Neg	7037	31 (0.44)	1 (Referent)		1 (Referent)	
Total	9139	62 (0.67)				
6 History of tattoo						
Yes	3703	37 (0.98)	2.18 (1.31 to 3.63)	0.003	1.87 (1.12 to 3.13)	0.017
No	5424	25 (0.46)	1 (Referent)		1 (Referent)	
Total	9127	62 (0.67)				

*Multivariate analysis was done using binary logistic regression by forward LR method. OR = odds ratio.

References

- 1 **Leruez-Ville M, Kunstmann J-M, De Almeida M, et al.** Detection of hepatitis C virus in the semen of infected men. *Lancet* 2000;**356**:42–3.
- 2 **Liu P, Shi ZX, Zhang YC, et al.** A prospective study of a serum-pooling strategy in screening blood donors for antibody to hepatitis C virus. *Transfusion* 1997;**37**:732–6.
- 3 **PNAS** 1992;**89**:187–192.
- 4 **Mehendale S, Shepherd M, Divekar A, et al.** Evidence for high prevalence and rapid transmission of HIV among individuals attending STD clinics in Pune, India. *Indian J Med Res* 1996;**104**:327–35.
- 5 **Sarkar K, Mitra S, Bal B, et al.** Rapid spread of hepatitis C and needle exchange programme in Kolkata, India. *Lancet* 2003;**361**:1301–2.
- 6 **Risbud A, Mehendale S, Basu S, et al.** Prevalence and incidence of hepatitis B virus infection in STD clinic attendees in Pune, India. *Sex Transm Infect* 2002;**78**:169–73.

Monosymptomatic hypochondriacal psychosis

Dr O'Mahony illustrates in his literary and graphic way the difficulties associated with dealing with this condition (from which his patient was almost certainly suffering).¹ It is good to know that his hospital is taking seriously the issue of actual or threatened violence to staff. Having had several similar cases over the past couple of years, including one who eventually committed suicide, I have been able to make appropriate arrangements with a psychiatrist who was unequivocal in his advice that he should be in on a subsequent consultation right from the start and be introduced to the patient as a double consultation. The ethics of this include the fact that such delusional patients are, of course, psychotic and unable to bring rational decision making processes to the problem.